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July-August 2003



Fleet Hospital Three

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COVER: ENS Jill Skeet administers pain medication to an unidentified Iraqi woman who arrived in Fleet Hospital Three's Casualty Receiving Room with a gunshot wound. Story on page 6. Photo by JOC Al Bloom.

A Special Visit by a Special Veteran

HMCM(FMF) Mark T. Hacala, USNR

In some ways it was nothing more than a hospital visit, a wounded veteran visiting wounded veterans. In some ways it was much more.

"Do you feel like seeing someone?" a Marine is asked. He has become used to it. Since his arrival at the National Naval Medical Center, his room has been inundated with well-intentioned visits from senators, congressmen, generals, and other well-wishers. "Sure," he replies.

A man with a trim white beard and moustache approaches the bed. Embroidered on the breast of his cream colored button-down shirt is a logo that reads "Suicide Charley, 7th Marines," the nickname for the Vietnam veteran's unit.

"Hi. I'm Doc Ingram," he says as he offers his hand to the young patient, who politely makes eye contact.

But then the Marine's eyes, a little glassy from his pain medication, are drawn a few inches lower. Around the visitor's neck, suspended from a light blue ribbon, is a bronze medal in the shape of a five-pointed star. The Marine's eyes suddenly widen and he struggles to come to attention in his bed.

Medal of Honor recipient Bob Ingram, a former hospital corpsman third class who was decorated for heroism with the Marines in Vietnam, felt he had to do something to help the Marines and Sailors wounded in Iraq. So he did. He took off work and traveled from Florida to Maryland to give encouragement to the returning casualties of war.

"I have a desire to do what I can in support of the troops, especially the Marines and even more, the 'docs,'" Ingram said.

That desire came from Ingram's own combat experience decades earlier. On 28 March 1966 Ingram's unit—Company C, 1st Battalion, 7th Marines—entered into a fierce engagement in Vietnam. During the fight Ingram sustained gunshot wounds to the hand, the knee joint, the groin, and a lateral shot through the face and base of his skull. At battle's end, Ingram's multiple traumas had made him unrecognizable to his own Marines.

Having returned from a battlefield to a naval hospital, Ingram knew what it was like for these Bethesda patients. "People had no idea what I had been through. They didn't know how to relate to me," he remembered. Ingram also knew that the shock of battle and the horrors of war create a need for emotional healing. "I just wanted to spend some time with them, alone, and let them know that I'm here if they ever need to talk," he said.



Photos by HM2 Rafael Acosta, NMETC

"Doc" Ingram.

Ingram's hectic schedule of visits on 11 and 12 April was delayed by several hours on the first day. Everyone in the hospital learned of President Bush's visit to the patients, which resulted in tight security measures and the heights of protocol. But Ingram wanted no fanfare, no formalities. In fact, only a few people in the hospital even knew he was there. "This isn't about me," he explained. "It's about them."

A registered nurse who manages a busy family practice clinic, Ingram maintains a sense of responsibility from his original medical profession. "I was a hospital corpsman," Ingram said to each of the Marines. "I'm still a corpsman. I'm *your* corpsman." He would then hand them his card and invite them to call him. Anytime.

As he moved from room to room, Ingram approached each situation differently. Most of the patients were in very high spirits, but their wounds varied in seriousness. With certain

patients he joked and got them laughing. Some had visiting family members present, and Ingram spoke with them all. Other times he simply listened.

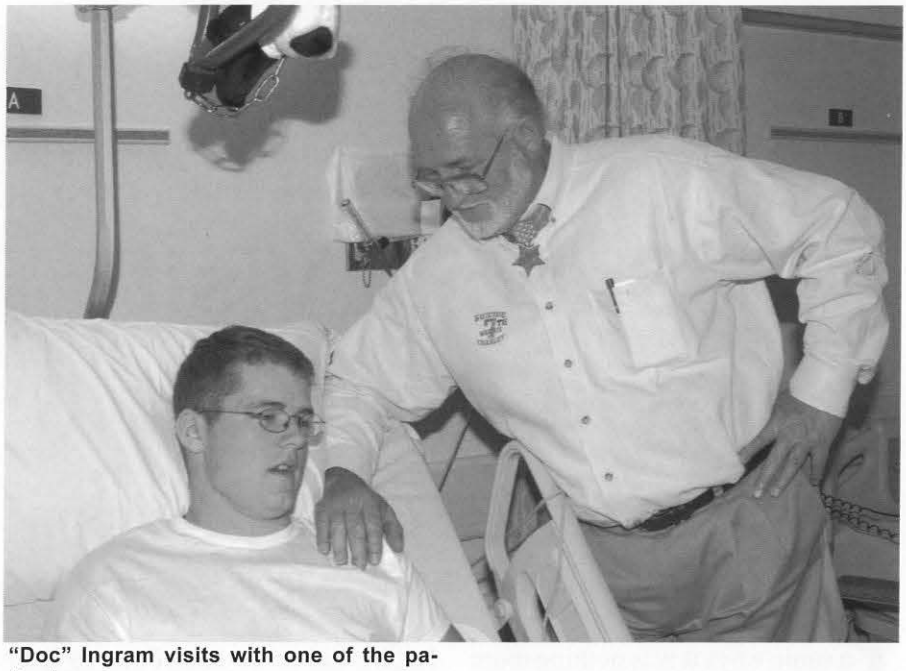
That would not be as easy as it sounds. Before him were patients who were early in their recuperation and straight from the fight. Their trim physiques and tight haircuts seemed to belie their age, making them seem far too young to be combat veterans. IV lines hung above them, steadily dripping medication into their arms. Bandages covered their abdomens and their limbs. Fresh scars showed the sites of life-saving surgery. For some, a dressed stump told a tragic tale soon to be covered by a prosthesis.

"I didn't know what to expect," said Ingram. "I didn't know how I'd feel." The visits were emotionally powerful, and many encounters brought to mind some of Ingram's own war experiences. "It was tough," he said.

Remarkably, although still hobbling or confined to their beds, most of these young servicemen exuded great confidence. Ingram was inspired. "For a lot of them it was their first firefight, their first time in combat," he said. "I was surprised to see how tough some of them were." Many expressed the desire to recover soon so that they could rejoin their units.

Before leaving the room, Ingram offered to pose for a photograph with the patient. One or two declined, perhaps not feeling well, perhaps not wanting to be photographed in a hospital bed. Most, however, accepted eagerly, as if they had been offered a winning lottery ticket.

In one room, Ingram knelt at the bedside of a young Marine, both of them smiling toward the camera. "Wait," the Marine said suddenly, "I want this in the picture." Straining, he slowly leaned toward his bedside table to retrieve a blue box containing the Purple Heart medal the President had given him that day. The Marine discreetly pulled his blanket over the dressing on his abdomen and covered that with the open medal box. With Ingram's hand on his shoulder, he then beamed into the lens.



"Doc" Ingram visits with one of the patients.

Ingram began the second morning by sitting down at a table with a stack of photographs taken the previous day. He autographed them all, personalizing each. One by one, he looked at the photos. "These kids aren't kids anymore! They're some of the finest men in the nation," he remarked. Seeing each image, he remembered his conversation with the Marine pictured and paused to think of the right words to write. "To my fellow comrade in arms, Semper Fi, 'Doc' Ingram," one inscription said. It was then up to the ward to continue the visits.

In all, Ingram met with close to 30 patients. Most were Marines; one was a Navy hospital corpsman. "I'm really proud of these guys," he said. "I'm proud they would talk with me." Still, Ingram worried aloud. "I'm not sure how much good this trip did. I hope I said the right things."

The command master chief of the National Naval Medical Center, CMDCM(SS,FMF,NAC, DV, PJ) Bill Sidwell, was convinced of Ingram's success. "I went up and talked to several of them and asked how they felt about it," Sidwell said. "All of them felt like they connected with him and that he truly made a difference. They felt that he helped them to open up and talk about the things that were on their mind."

LCPL O.J. Santamaria, recovering from a shoulder wound received in Nasiriyah, was overwhelmed by Ingram's visit. "Oh, it was awesome! It was really motivating. I mean, here he was, wounded four times in Vietnam...it was incredible!" This from a man who had just had his citizenship oath administered by the President of the United States.

Perhaps another Marine summed it up best. "Doc Ingram made me think. He made me think about what I knew that I needed to face but was hesitating to face," he said. "He needs to know his visit did and will make a difference in my life." ❑

HMCM(FMF) Hacala is Command Master Chief of Naval Reserve BUMED 106, and Director of the Education Institute, U.S. Navy Memorial Foundation, Washington, DC.

NIDBR and VA Partnership Doing Great Things for Warfighters and Veterans

LCDR Michael Bilak, MSC, USN
CDR Stanton E. Cope, MSC, USN

During a time of diminishing resources, the Naval Institute for Dental and Biomedical Research (NIDBR, formerly the Naval Dental Research Institute) has found an innovative method of expanding command research capabilities and services through active partnering with the Chicago area Veterans Administration hospitals.

With the chartering of the NIDBR/VA Research Steering Committee in February of 2002, what began as a simple memorandum of understanding between NIDBR and VAMC North Chicago for emergency veterans' coverage has now expanded into a full partnership in research. "From its inception the goal of the NIDBR/VA Research Steering Committee has been to expand research and increase research collaboration through the mutual sharing of non-financial resources such as research expertise, space, and research support," stated CAPT James C. Ragain, Jr., DC, USN, NIDBR's commanding officer and current Steering Committee Chair.

NIDBR and the Chicago area Veterans Administration hospitals have already benefited from this partnering initiative. Currently, NIDBR supports the North Chicago VAMC by providing veteran services and biostatistical consultation while the North Chicago VAMC has provided five offices and two outstanding laboratories to house NIDBR's Bioenvironmental Sciences Department.

To showcase this partnership, NIDBR in collaboration with the VAMC North Chicago, the VAH Hines, the Army Dental Research Detachment, and the Air Force Dental Investigation Service have held two major events this past year. In April over 120 research posters from several institutions in the Chicago area were showcased at the Hines VA. The guest speaker for the event was the CO of NIDBR, CAPT Ragain. In August a Joint Research Symposium highlighting the research projects conducted at the VA and the DOD facilities in the Great Lakes area was held. This all-day event featured 25 speakers including RADM Ann E., Rondeau, USN, Commander, Naval Training Center Great Lakes, and Congressman Mark Kirk.

The ultimate goal of this research partnership is the development of mutual interest research areas that are militarily relevant and support the active duty warfighter and the veteran. To this end, NIDBR and VA researchers are currently exploring several opportunities for collaborative research including development of synthetic skin, use of rapid salivary diagnostics to detect cancer, and treatment of severe hemorrhagic shock.

For over 50 years, researchers at NIDBR have investigated problems related to oral health, disease, and injury and developed techniques and products to improve dental and medical care in the Navy. With the co-location of the Army Dental Research Detachment (1996) and the U.S. Air Force Dental Investigation Service (2000), the Institute is the site for all DOD dental research. ❑

LCDR Bilak and CDR Cope are assigned to the Naval Institute for Dental and Biomedical Research, Great Lakes, IL.

Fleet Hospital Three Testing a Patient Tracking System

In southern Iraq, Fleet Hospital Three is successfully testing a unique patient tracking system. The Tactical Medical Coordination System (TacMedCS) is a wireless communication system that uses radio frequency (RF) technology to capture and display real-time casualty data in the field. TacMedCS, originally designed for FMF corpsmen to locate injured Marines during urban combat and record medical care, was reconfigured to meet the needs of Fleet Hospital Three.

HMC Michael E. Stiney, USN, a cardiovascular technologist and FMF corpsman, is the TacMedCS project manager at the Naval Aerospace Medical Research Laboratory (NAMRL) in Pensacola, FL. He said, "The NAMRL team briefed the fleet hospital commander and senior medical officer on the potential use of TacMedCS to track the flow of casualties through the facility while deployed. They asked if we could modify the system to meet their specific needs. We did."

In just 1 week, NAMRL deployed 800 wristbands, a wireless network complete with relays and antennas, a laptop with the database, five scanners, and a server.

At the time, the original system in development included three components:

•A small plastic tag, about the size of a dog tag, with embedded RF electronic read/write chips storing medical information for a Marine to wear during combat.

•A palm-sized scanner for the corpsman to electronically read and write to the tag.

•A central server with a database and a digital map display of the operational areas at a command center.



U.S. Navy Photos

LT Everhart reviews the laptop database used to track patients.

With 4 years of research and multiple field trials during Marine Corps exercises to their credit, the NAMRL team, working with their civilian partners, already had the chips, scanners, and server needed by Fleet Hospital Three. Instead of tags, the fleet hospital wanted wristbands, an easy task for the team. The real obstacle was rewriting the software to capture the information the fleet hospital needed.

Stiney said, "TacMedCS was ready for field use during this operation. The same technology that goes into the tags was put into patient identification wristbands. Each wristband has a prerecorded number to identify the casualty. From the point a casualty enters the fleet hospital, all records are linked to the number on the band."

The point man for the test is LT David Everhart, NC, USNR, a casualty receiving nurse and the Nursing



The wristband used in the TacMedCS wireless communication system.

Informatics Officer with Fleet Hospital Three. He is putting TacMedCS through its paces in southern Iraq. Everhart said, "The software was re-configured by the NAMRL team to accommodate our anticipated casualty structure. We provided a list of requirements to the programmers and had a fully operational system with easy to follow user guides in what seemed like overnight. Once deployed, we identified several areas that would improve the data collection capabilities. This was especially evident when the patient population shifted. We found that our initial requirements provided to NAMRL were not as robust as we actually required once we began to see a wide variety of patients. From a beta test standpoint, I feel that this has been very successful. Although we experienced some software problems initially, we have the system in place and working as anticipated."

Everhart explained how TacMedCS is being used at the fleet hospital. Fleet Hospital Three is an Echelon Three 116-bed facility that covers 9 acres. It includes a casualty receiving unit, four OR beds in two rooms, three impatient wards, and an ICU. Ancillary services include laboratory, radiology, and pharmacy suites. The hospital receives patients primarily from forward surgical units and also serves as the "community hospital" for their region of operation. Each patient is entered into the TacMedCS system. The patient admin staff assembles charts for each patient, which includes a TacMedCS wristband. The patient's wristband is scanned by the casualty receiving corpsman, injuries and treatments are documented, and the patient is then moved to one of the three wards, the OR, or the ICU. Movement through the facility is recorded and tracked by scanning the wristband. When the patient leaves the facility, the wristband is scanned and the final disposition is electronically written to the wristband. The majority of patients enter into the MEDEVAC system, and are transported to the next level in the continuum of care.

He went on to add, "We deployed the system to encompass the mission and introduce the hardware and software to the strenuous environmental conditions that we are experiencing here. The dust from the sandstorms is probably the most significant potential hazard to the hardware, as well as the heat and transport issues. So far, we have not experienced any hardware failures that are detrimental to operations."

"The support that I have received from NAMRL has been truly stellar," said Everhart. "We lost all the software on the handheld units when we unpacked them due to power loss in transit. Once I contacted NAMRL they responded immediately and had solutions to me in record time. Given the limited communications we initially had, coupled with the time difference, this was no easy task. Once we established e-mail, they were available 24 hours a day with guidance and technical support for every question I posed to them. They continue to monitor our progress with the system and have already implemented changes based on our findings here in the field. I could not be more satisfied with their level of dedication."

"As a real-time patient-tracking device, TacMedCS has proven it's worth," added Everhart. "The technology has enormous potential in my opinion, especially if we could implement it on a theater-wide basis, with the initial data being recorded in the field at the point of initial care. By migrating the technology to a complete bedside documentation package, it could provide a continuum of data from the point of injury, hospitalization, and evacuation across the echelons of care. As these data travel with the patient, an entire medical history could be assembled and stored on the wristband or tag."

What is the next step? According to Stiney, "We are going to take the data captured at the fleet hospital and capitalize on the lessons learned from this experience. This is not a 100 percent completed system yet, so we are going to take the information gathered by all the users over there and fine tune the system to create a better product. I think we will have a final product ready in a year. TacMedCS will be adaptable to requirements – preventive medicine, trauma treatment, casualty evacuation, and humanitarian assistance. Whatever Navy medicine's requirements are, we will deliver." ❑

—Story by Doris M. Ryan, Medical Research and Development Division (M26P), Bureau of Medicine and Surgery, Washington, DC.

Fleet Hospital Three Makes Navy Medical History in Sands of Southern Iraq

JOC Al Bloom, USN
Rod Duren

The responsibility of providing casualty care during Operation Iraqi Freedom has taken on a new look. While care is still delivered in the traditional manner by battlefield corpsmen and field surgery units, the men and women of Fleet Hospital Three (FH-3)—beginning 1 April—added to the lifesaving capabilities of Navy medicine by constructing the Navy's first Expeditionary Medical Facility (EMF) in a war zone.

"I am truly impressed with the way the Fleet Hospital has come together here," said the Commanding General of the First Force Service Support Group (1st FSSG) BGEN E.G. Usher shortly after FH-3 started seeing patients.

"The teamwork displayed to get this great facility up and running and operationally capable, while almost simultaneously starting to see patients, has been amazing."

"The result a significant increase in our ability to save lives," said CAPT Peter F. O'Connor, Fleet Hospital Three commanding officer.

FH-3 was a 9-acre, 116-bed Echelon III facility manned by more than 300 medical service support personnel and Construction Battalion personnel.

"Echelon One is the treatment provided in the field by our physicians and corpsmen who travel and risk their lives on the front lines," explained HMCM(FMF/SW) Don L. Nelson. "Without their efforts, our work would be all but impossible."



Photos by JOC Al Bloom

Vascular surgeon, CAPT Hans Brings, prepares surgery instruments for sterilization.

Even after receiving treatment from a field corpsman, a service member can receive care from an Echelon II facility known as a Force Service Support Group Surgical Company, but these companies, while mobile and capable of providing vital surgical capabilities, are not nearly as robust as a fleet hospital.

"When we arrived at Camp Viper, the folks attached to Charlie Surgical Company, (Force Service Support Group, First Marine Expeditionary



An unidentified coalition forces patient waits aboard an Air Force C-130 while FH-3 casualty receiving personnel back an ambulance up to the cargo door to deliver additional patients for evacuation.

Force) were busy receiving patients," said FH-3 Executive Officer, CAPT John S. Gibson, who lead the advance party move from Camp Luzon, Kuwait, into southern Iraq to start construction of the fleet hospital. That trip was through a sand storm that turned a 5-hour trip into a half-day, blinding excursion. "We all knew Charlie Company was getting ready to move forward to keep pace with our forces."

Getting to work meant the Seabees would begin surveying and grading the desert site. Upon completion, the remainder of the FH-3 staff would begin erecting tents and placing and installing equipment ranging from surgery and x-ray suites to crews' living quarters and galley.

Treating "all" patients

As FH-3 completed its medical/surgical assignment during the latter days of May, the staff had seen more than 600 patients and performed more than 315 surgeries. FH-3 had provided compassionate care to all, including lifesaving support for Operation Iraqi Freedom, and tangible battlefield benefits.

"We arrived here knowing full well that we'd be needed," said CAPT O'Connor. "We also knew that we'd be treating all comers. We were to take care of everyone in need of our care ... it's what we do."

"We treated all patients regardless of their nationality" said HM2 Connie Martini, "To tell you the truth, there have been times when [Iraqi patients] were obviously untrusting and a little combative," said the ICU corpsman.

"One patient in particular came in and clearly didn't trust us," added HM2 Martini. "He had a pretty bad attitude and even went as far as pulling out his IVs. But by the time he left, he saw firsthand that we were really here to help. He wrote down a note that we had translated. *'Saddam bad: America good.'* That note meant a lot," she said.

"Right now we're one of only two Echelon III hospitals in the entire country of Iraq," said CAPT Gibson describing the robust capabilities available at FH-3. "The majority of hospitals here are located in Baghdad, and considering how hard they've been hit by looting and the war, it'll take some time until they're back on their feet and capable of receiving patients like they were.

"That said," added CAPT Gibson, "the southern part of Iraq didn't have much in terms of hospitals prior to the war. The Iraqi people need our assistance. We're the best they've got right now."

Considering what FH-3 brings to the table it may indeed be the best hospital currently in Iraq. After constructing the $12 million facility in the desert, FH-3 personnel brought their mix of expertise to bear.

"We've got a strong mix," said HMCM(FMF/SW) Nelson. "The vast majority of our folks, whether in casualty receiving, x-ray or surgery, nursing and in our (laboratory), were hand picked."

"We're capable in providing several different disciplines in surgery," said FH-3 Director of Surgical Services, CAPT Charles Reese. "We have specialists in neurosurgery, ophthalmology, orthopedics, a vascular surgeon, and I'm an ENT (ear, nose and throat) specialist. Plus, we also have some outstanding general surgeons."

Specialty shortage

Unfortunately, one other specialty area available at FH-3 has been busier than anyone desired. "We've got a pediatrician who has seen more

than his fair share of patients," said FH-3 Director of Medical Services, CAPT Bob Hoyt. "Many children arrived with families, and to see them going through that sort situation and trying to make the best of it was moving. The way our staff responded, it was easy to see that they weren't just folks in a modern facility. They were doing their best to ensure there was a healing process," said the NH Pensacola internal medicine specialist.

"We had one child with a shrapnel wound to the foot that virtually everyone fell in love with," said FH-3 pediatrician, LT Carlos Williams. "We've got a lot of parents out here. That parental love crosses all lines. The love of a child allows us to recognize our common ground," Dr. Williams pointed out.

"This hospital is our only hope," said Dr. Hassan Ali, an Iraqi physician who accompanied a 12-year-old boy from Baghdad to the fleet hospital. The youngster suffered wounds to both legs and chest when a piece of ordnance exploded while he was playing with it. "Our hospitals are all unable to see patients," he said. "The doctors have all fled in fear that looters will hurt them in order to take drugs and medical supplies.

"It's harder because you want to be able to do something to soothe the children," explained operating room technician, HM2 Bradley Gann. "They're disoriented, in a place often by themselves, and we have a hard time communicating.

"Even when they arrive with family, the parents are often apprehensive," added the corpsman. "We had one little girl with a bullet wound and the father was here. But he had a hard time trusting us. We were able to communicate through an interrupter that his daughter's well-being was the most important thing to us. It really hit home, because I have a son who is about her age."



After delivering 166 trucking containers filled with more than $12 million in medical equipment and supplies and then constructing a 116-bed facility, FH-3 personnel unpacked and placed surgical equipment in one of the facility's two surgery suites.

"I hold the care of the sick and injured to be a privilege and a sacred trust..." reads the Hospital Corpsman Oath. Maybe it's not really that difficult to reconcile the treatment of battlefield casualties regardless of nationality after all.

Training, training ... and training

"Our folks went through more than a week of hands-on training at FHOTC (Fleet Hospital Operations and Training Center) in Camp Pendleton, CA," said HMCM (FMF/SW) Nelson. "Then we successfully completed a 3-day Operational Readiness Exercise (ORE). We had to be sure we were capable of putting the hospital together once we arrived in country. We are our own construction work force."

Adding the two training evolutions together, FH-3 personnel garnered more than 70,000 man-hours of training. After years of planning, training, and pre-positioning, there was still one more integral role to be played to ensure the successful build of FH-3.

"The construction of any fleet hospital would be impossible without Construction Battalions," said CAPT O'Connor. "From the preparation of our initial camp in Kuwait and their driving our equipment through a blinding sand storm in the advance party to the non-stop, 24-hour days they put in once we arrived in Iraq, our Seabees from CBU 412 and CBU 402 have done a magnificent job." "Bottom line, this has been a shining example of the definition of teamwork, added CAPT O'Connor. "I've said it before to our families. This is the best fleet hospital in the Navy and I'm proud to be a part of it."

Twenty-eight days after receiving orders; 24 days after flying to Kuwait; 7 days after traveling through a blinding sand storm; 5 days after beginning construction in the desolate environment of the Iraqi desert; and 2 days after treating their first patient, Fleet Hospital Three took a moment

to extend their pride in teamwork homeward. In a brief ceremony they reflected on their accomplishment and raised a flag that had flown over Naval Hospital Pensacola to signify the strong bond between everyone in Navy medicine, whether at home or in the field.

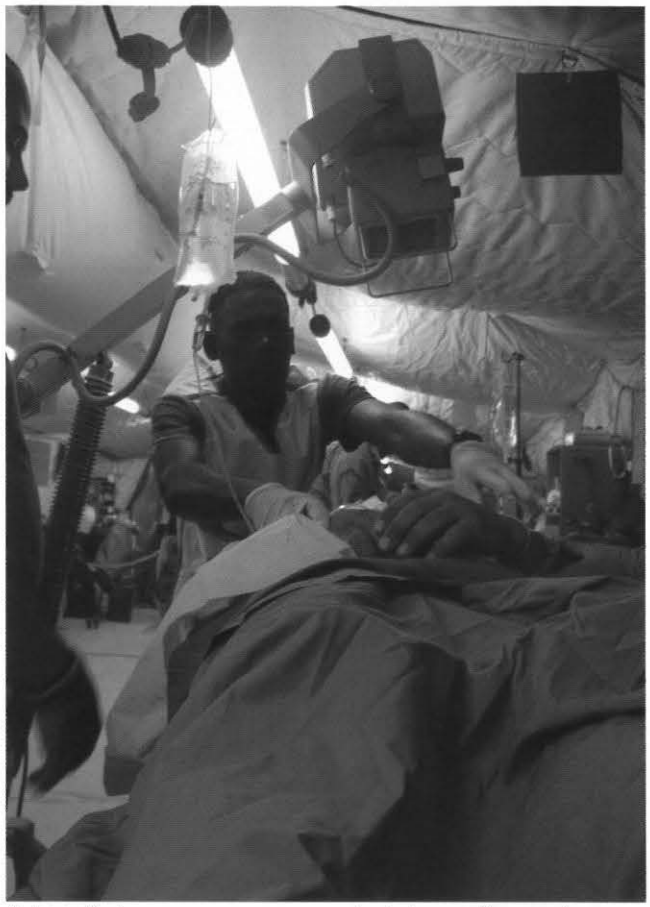
Then ... they went back to work.

Upon opening for business 1 April, "the surgeons were operating 24/7 during that first week. It was nonstop," said CAPT Pam Roark, head of nursing.

"The nurses were working 12-hour shifts yet it's been the most rewarding experience in my nursing career," said the 22-year Navy Nurse Corps officer.

After the first weeks of war, FH-3 was "surprised" and nearly overwhelmed with civilian patients and enemy prisoners of war, including women and children, some of whom had purportedly been used as human shields.

LCDR Suzanne Timmer, a pulmonary critical care physician, saw no faces of an enemy, but said the sole purpose of her being with FH-3 was "to take care of people just as I do at home."



A hospital corpsman prepares to take an X-ray of an unidentified Iraqi prisoner of war who arrived at FH-3 with a gunshot wound.



HM2 Sara Beishir and a crewmember of an Army UH-60 Black Hawk transfer one of the more than 500 patients seen by FH-3 staff.

FH-3 must have done a miraculous job. No U.S. or Coalition Forces' injuries were fatal.

Some of the wounded soldiers that came into FH-3 had significant combat injuries, said CAPT Roark with an awe-inspiring hint to her voice, "but their only concern was about getting back to their units ... not talking about going home."

Language and children

There were several experiences FH-3 staff had involving children and families and an initial misunderstanding based on language.

"We had placed a child on a ventilator to transport to a Kuwaiti



HM3 Patrick Agan prepares for surgery just hours after FH-3's construction.

children's hospital," said Dr. Timmer. "We'd gotten the child into an ambulance, the father was following, and the equipment died."

The doctors placed the child into a different ambulance, with a working ventilator, and sped off quickly for Kuwait.

"The look in his eyes told me what he was thinking," said LCDR Timmer, "that his daughter had died ... and I didn't have the skills of speaking the language to explain it initially."

CAPT Roark had a different experience with an Iraqi man who had been helping the U.S. troops with information. He was later shot in the arm by soldiers when he failed to heed warnings because he hadn't heard them, she said. The medical team had to amputate his arm above the elbow.

"I told him I felt very badly that he had lost his arm," said CAPT Roark. "He said his family had not known freedom for more than 35 years, and that he would gladly give his other arm for freedom."

"Ground zero for nation building"

LT Dallas Braham, a Navy nurse and reservist, who was recalled to active duty in February, has spent the past 11 weeks as part of Navy medicine's historical FH-3.

He hadn't given much thought to the "historical" aspects of being the first EMF in a combat zone or the "austere living and working conditions we were in and level of care we provided," he said recently as the command prepared to complete its duties in southern Iraq as a combat field hospital.

"Until then, we simply had a task to perform and we have done it extraordinarily well," said the ICU nurse. "We have shown that several aspects of Navy medicine can meld together to be the immediate support for the 'pointy end of the spear.'

"We are not warriors," he continued, "but through our care, we have provided tactical support and have been, as one of my close friends said: 'ground zero for nation building.'"

FH-3, through the trust it has built among the citizenry, has saved many lives outside the hospital and "some patients' lives and outlooks within the hospital have even begun to be rebuilt," said LT Braham. "Our success here will change the course of Navy medicine in the field," said the 40-year-old Navy nurse.

In describing one of the more moving experiences while being a part of FH-3, LT Braham, the father of three young children, said the most difficult aspect of the deployment has been "caring for the wounded children. It was tough on me."

"I spent several hours one night caring for a young girl who had received a gunshot wound to the head, reportedly from celebratory gunfire near the city of Basra soon after the liberation of that area began," the critical care nurse continued.

"Through an interpreter, I spent much of that time conversing with her father as I hovered over his daughter. We spoke of our families and how protective we were of our daughters," said LT Braham who had missed the birth of his third child while deployed.

"Through him, I think I got my greatest affirmation of our purpose to care for their wounds and for our forces to liberate these good people from the tyrant that has ruled over them." ❑

JOC Al Bloom, is Public Affairs Officer for Fleet Hospital Three, Southern Iraq.

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Who Are the Combat Dental Techs?

DTCS(AW/FMF) Democrito S. Gamboa, Jr., USN

Operation Iraqi Freedom: The mission was to liberate Iraq from a dictator and stop production and proliferation of weapons of mass destruction. Many were called to serve and fight, including Navy dental technicians. Surprised? Aren't dental technicians supposed to be working in the comfort of an air-conditioned dental office at National Naval Dental Center Bethesda or in the company of 5,000 people aboard an aircraft carrier?

The 55th anniversary of the dental technician rating was observed in April and it's high time that we recognize the personnel who support and fight with the Marines. These Sailors who are assigned to the Marine Corps are the "Combat Dental Techs," more officially known as field service dental technicians. Their mission is to provide dedicated healthcare to Marines wherever and whenever needed.

Fleet Marine Force dental technicians attend 7 weeks of challenging training with hospital corpsmen in one of the two Field Medical Service Schools at Camp Lejeune, NC, and Camp Pendleton, CA, learning life saving and combat skills.

Instructors teach life saving skills with lectures and the students practice the application of those skills using a lifelike rubber mannequin. The goal is to focus on providing emergency medical care to combat casualties.

In developing their combat capability, students learn weapons proficiency training, combat patrol, nuclear, biological, and chemical warfare, and navigational aid techniques. To complete the course, students become familiar with the 9mm pistol and M16-A2 rifle. The curriculum also includes daily physical conditioning exercises and forced marches in full gear.

Upon graduation, field service dental technicians are assigned to one of three dental battalions within the FMF—the 1st Dental Battalion at Camp Pendleton, 2nd Dental Battalion at Camp Lejeune, NC, or the 3rd Dental Battalion in Okinawa, Japan. While stationed with FMF units, dental technicians (with the dental officers) are accomplishing a three-fold mission: to provide comprehensive dental care to Marines in garrison, accompany deployed units to continue general dental service, and to augment medical units on call in support of combat casualties.

The history of dental technicians working side by side with Marines is rich with pride and heroism. During the invasion of Iwo Jima, dental technicians carried out regular duties and assisted in sick bays and operating rooms. In 1950, Dentalman Thomas Christensen was posthumously awarded the Navy Cross for extraordinary heroism while trying to save wounded Marines under intense enemy machine gun, grenade, and small arms fire in Korea.

From June 1965 to January 1973, the 1st, 3rd, and 11th Dental Companies, along with detachments of the 15th Dental Company provided support to Marines serving in the Republic of Vietnam. As a result, dental technicians earned Silver and Bronze Stars, Purple Hearts, and other personal medals and citations during the conflict.

In 1983, DT2 Paul Dziadon, DT3 Richard W. Fly, and DN Manuel Bernal were recognized for their outstanding performance after the bombing of the Marine Barracks in Beirut, Lebanon.

Dental field service technicians were also in high demand during Operations Desert Shield and Desert Storm. They treated dental emergencies, reinforced medical companies, stood sentry duty, set up field dental equipment and field hospitals, operated decontamination stations, and stood ready to assist in any way in the liberation of Kuwait.

In peacetime, field service dental technicians can be found with peacekeeping forces, Marine Expeditionary Units, and other field exercises and deployments.

The "Combat Dental Techs" are trained to serve with the United States Marine Corps and they will continue to do so with pride. ❑

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Preventing Disease in Marines

CDR Scott Sherman, MC, USN

A Navy preventive medicine team was busy working in central Iraq supporting Marines and Navy medical personnel here during Operation Iraqi Freedom.

The 12 members of the Preventive Medicine Mobile Medical Augmentation Readiness Team 5 (PM-MMART 5) spent months preparing for the deployment and mounting an offensive against the preventive medicine challenges that are critical to maintaining a robust force health protection (FHP) posture.

The team was made up of five officers and seven enlisted personnel who have expertise in medical entomology, preventive medicine/environmental health, microbiology, and industrial hygiene. The team was also capable of analyzing a wide range of chemical, biological, and radiological warfare agents.



Photo by author

Members of PM-MMART 5 embark with their equipment on a C-141 out of March AFB, CA, 28 March.

Medical staff and Marine operational staffs worked together to deploy three of these public health surveillance teams into theater: one in Ad-Diwaniyah in central Iraq, one in southern Iraq, and one in Kuwait to provide advanced diagnostic and specialty consultation to medical officers and operational commanders. Their presence was essential, according to CAPT Joel Lees, 1st Marine Expeditionary Force Surgeon. "Team 5 was a great asset to us!" says Lees. "They were able to rapidly tackle some potentially important public health issues for us and get good advice out to the commanders and their medical staffs in time to help keep the problems minimal."

Shortly after arriving, PM-MMART 5 made the first laboratory diagnoses of malaria, shigella, and norovirus in Marines and Sailors in Iraq. "We concentrated on preventing or mitigating that subset of medical issues that can rapidly degrade the combat power of the Marines," said CDR Scott Sherman, medical team leader and public health physician. "Because of our range of expertise and specialty equipment, we get involved in a very wide variety of medical issues that have the potential to cause acute disease or are of concern for chronic exposures."

The team was extensively utilized by elements of the 1st Marine Expe-

ditionary Force for mosquito control operations, water testing, blood/stool testing for infectious agents, epidemiological consultation, environmental sampling, safety consultations, traditional field sanitation and hygiene issues, and analysis of unusual chemicals or vapors in camp areas and at one of the liberated palace compounds.

"The Commanders did a good job identifying areas of concern," said LCDR Lucy Walker, PhD, industrial hygiene specialist for PM-MMART 5 and assistant team leader. "We were able to go in, characterize the nature of the exposure and give them good, practical advice on how to reduce the threats and then document those exposures for the ongoing Force Health Protection program."

HMC Robert Hunt, the leading chief petty officer with the team, added, "The PM technicians out in the field with these units do a great job in keeping the disease and non-battle injuries (DNBI) down in their units; this is a tough place for public health and they are keeping DNBI very low."

In addition to the individual expertise of the members, the team deployed highly technical equipment that gives them the ability to do advanced microbiological analysis (PCR, Elisa, culture, fluorescent antibody) and sophisticated water and toxic chemical testing from colorimetric to gas chromatography, mass spectroscopy, and infrared spectroscopy.

The PM-MMART teams are an outgrowth of the "forward deployable laboratory" utilized in the Gulf War and Somalia. Over the last decade the Navy Environmental Health Center (NEHC) has funded and trained six of these deployable teams to help to ensure robust FHP for deployed forces. Over the next 2 years the teams will complete the transition to Forward Deployable Preventive Medicine Units (FD-PMUs).

After staging and coordination from Camp Luzon, TAA Coyote, Kuwait, the team loaded up on Seabee vehicles and joined an Army MP convoy to travel to central Iraq. The camp was on an abandoned health sciences university campus and had been occupied for only a few days when the unit arrived. Due to the large amount of destruction from looting after the war began, the camp was an abundant source of preventive medicine challenges for all aspects of the team — chemistry, microbiology, vector control, sanitation, and basic preventive medicine.

Under the direction of LTJG Christensen, a consolidated preventive medicine effort of all PM assets in the camp successfully brought the camp from red to amber status and improvements were made daily to move the camp toward green. The team provided consultation for building habitability, shower and head placement throughout the camp, proper handling and disposal of hazmat found in buildings, and any other concerns that unit PMTs needed advice on.

The entomology component from DVECC conducted daily vector control operations throughout settled camps and unit staging areas. Word quickly spread throughout the area that pest control capabilities had arrived; therefore, requests for fly bait and mosquito spraying came in daily through the unit PMTs. All standing water, catch basins, and flooded dry wells throughout the camp facility were sampled/treated for mosquitoes. Fly bait was laid in all latrines and delivered to 1stMarDiv for use in their staging area.

The chemistry team leader was busy conducting walkthroughs of the numerous chemical labs and warehouses throughout the university complex. Issues such as classification of asbestos, identification of unknown substances, and field expedient remediation advice requests came in daily. The microbiology team was busy with classification of a widespread diarrhea problem that was moving throughout the Sailors and Marines in the area of operations. Specimen collection kits for fever/diarrhea clinical samples were provided to many battalion aid stations to obtain clinical samples to characterize disease/illness.

Future operations of PM-MMART 5 will involve conducting Environmental Baseline Surveys for camps occupied by coalition forces for more than 30 days in the theater of operations. This is a new requirement in the ongoing plans to provide comprehensive Force Health Protection for deployed personnel. As part of the surveys representative soil, water, and air samples will be analyzed locally using mass spectroscopy, gas chromatography, and various reagent test kits appropriate for "field" analysis and then forwarded to the U.S. Army Center for Health Promotion and Preventive Medicine for confirmatory testing and historical categorization of environmental exposures encountered by deployed personnel. ❑

CDR Sherman is assigned to NEPMU-5, San Diego, CA, and was deployed with PM-MART 5 in Iraq.

Project Windstorm
A Cold War Memoir

CAPT James Helsper, MC, USNR

Part III

The smell of frying bacon and freshly baked bread, soon followed by the sound of reveille played over a hastily set up loudspeaker, woke us the next morning. There were long lines of men waiting to use the few toilets in the hangar, and it was obvious that the creation of latrines and, hopefully, showers, would be an early priority.

Dick and I thought some men might have tried to stow away on the departed ship after seeing the island, but everyone was accounted for at morning muster. Work parties were sent off to make the place more livable and it was amazing how well things went. Sick call was more psychiatry than organic illness, and it went well also.



Photos courtesy of author

Infirmary

On our very first day, however, we had our first accident. A carpenter caught his hand in a wood planer, resulting in a nasty injury. We had to unwrap some of the instruments and boil them in pots in the galley; that's after we got the damned Cosmoline off the instruments. Hand injuries can be very dangerous, and can easily cause permanent damage to the hand, with infection always a significant hazard. Our corpsmen crew turned to, and right there in the galley we performed the surgical repair to the hand, under an excellent nerve block given by Dick. We spent several hours helping each other, as if we had done it forever, and we were proud of our work as we wrapped the carpenter's hand in a giant bandage at the conclusion of the procedure.

We met at the hangar for lunch, where an area had been cordoned off to serve as the Officers' Mess. Dick stopped me from just sitting down at any table, saying the skipper had demanded full military courtesies at every meal. That meant we would be seated according to rank and date-of-rank, and also that each table would have a designated senior officer; no one could begin eating until the senior officer was seated and had begun to eat. I didn't believe Dick, but it certainly proved true. Dick and I couldn't even sit together. And if the



R.H. Hood, Jr., MD.

senior officer at the table was detained, permission to begin eating had to be requested from the skipper or another senior officer.

Home on the Tundra

Some of the vehicles were assigned. We had requested two jeeps but were given only one, plus the ambulance. It was time to find a permanent location for rendering medical care. We decided, then and there, to advance the title of our facility (from Dispensary) to Infirmary, the next level of health care facility in the Navy lexicon. We briefly considered Hospital, for morale purposes, but couldn't bring ourselves to go that far. Infirmary it would be, even though we wouldn't fill all the criteria for that designation.

We found the site used by the Army as a medical facility, which appeared to be in a somewhat dilapidated condition, but we felt it could be used. In size, it was rather luxurious, with more rooms than we needed. After all, there had been over 5,000 army troops on the island previously, receiving medical care here. There were rooms for a 20-bed ward, an operating room of sorts, a laboratory, and an x-ray room, several offices, and more rooms which we could use for storage. No equipment of any kind had been left behind, but some furniture and beds remained. There was no heat or power, but after seeing what had been accomplished at the hangar, we felt that should pose no problem.

Returning to the afternoon meeting, we presented our request, and noted it ranked fairly far down the "To Do" list. Dick and I realized the skipper wasn't counting on the high rate of hypochondriasis among the Seabees. We were relieved to see various officers and foremen pushing the Infirmary rehabilitation up the list, and though no one said much, it wasn't long before we saw wires strung from the main generator, and a huge portable heater was dropped off at the site. Next, electricians and plumbers were making connections and within a couple of days we had an Infirmary. We had to run sick call at the hangar for a while longer, but the corpsmen with us soon moved into our new facility and began installing laboratory equipment, the portable x-ray machine, and our pharmacy. Gus set up his dental chair and other equipment in one office, and began taking appointments for dental care.

We were busy cleaning Cosmoline from the surgical instruments, and getting the autoclave ready for use. Surgical packs were created and sterilized, and the operating room lights,



The wind blew the paint off the infirmary before it could dry.

which had been stored in footlockers, were set up. Each of these lights had a battery case at its base, since they were all combat packs as used by surgical teams in field tents. It wasn't long before we felt we were ready in the case of an emergency. The small x-ray machine worked, but it lacked many of the refinements. We brought our first surgical case from the galley, and x-rayed his hand, and were relieved to see he had no fractures. We dressed his wounds daily, and were pleased to see the multiple wounds heal without infection. We permitted him gradual return of function of his hand, and he ultimately healed completely.

Dick and I decided to share the same office so that we could discuss cases (and shoot the breeze to help allay our own loneliness). There were endless reports to be done on a regular basis, as well as the onerous reports that had to be generated almost daily. Thank God the corpsmen knew what to do. Best of all, by sharing the same office space we were able to discuss surgical problems, and therefore teach each other. We took a chapter in a surgical text each week to quiz each other, hoping to keep from getting stale. What we missed most were our surgical journals, the lifeblood of keeping up with surgical techniques.

The Quonset huts were all examined, and made livable for as many men as possible. Dick and I were assigned to an 8-cubicle officer's hut, and after the space heater, plumbing, and electricity were installed we moved in. These living quarters were Spartan, with a bunk, a reading light, and a small shelf for clock, radio, and toiletries.

Since Amchitka was close to the action during World War II, the Quonset huts were all dispersed and partly covered with tundra to protect them from frequent air attacks while the Japanese were on Kiska and Attu. The huts were scattered all over and facing in different directions. With the weather as it was, and until the road gangs made footpaths, everyone just stayed in their Quonsets. Rumor had it that there had even been a "bed check Charley" flight over every night, just out of gun range, harassing the troops.

The enlisted men were moved into double-decker bunks, with 16 to 24 men to each Quonset. Some were left to live in the side rooms in the hangar, a desirable option since it meant going straight to work without having to dress to face the elements. These were mostly cooks, bakers, and yeoman. Meals were all taken in the hangar, and various offices were also set up there. Movies were shown in the hangar each night, and the big mission job—termed "the dig"—was always open for discussion. Roads had to be built somewhere near the middle of the island. A gravel pit had to be located, and the drilling equipment for the shafts had to be set up at the site.

The miserable weather continued, with winds of 30 to 40 knots blowing steadily, even occasionally gusting to 100 knots. Our weathermen went out to measure the wind speed on his first day, using his hand-held wind anemometer. Immediately it spun up to its maximum and then broke due to the high wind. We were never able to report wind speed accurately thereafter. Snow was intermittent, and mostly horizontal. The wind was so great that snow was blown right off the island. Visibility was so poor that rope railings had to be rigged as guides to the Infirmary and to the Quonset huts below the hangar.

Our first introduction to the tundra that covered the island came when the road building crew came to report the tundra had swallowed a heavy bulldozer. ❑



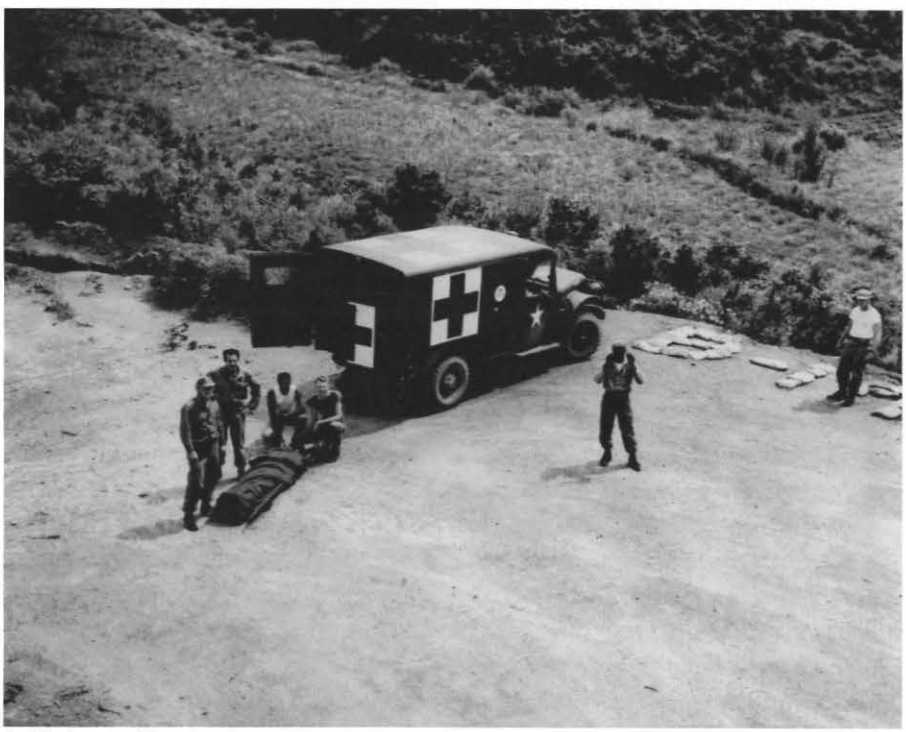
Our trucks and winterized bulldozers.

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Navy Medicine in the Forgotten War Korea 1950-1953

Part V (Conclusion)

CAPT Eugene H. Ginchereau, MC, USNR (Ret.)



BUMED Archives

A Marine guides in a medevac helicopter from HMR-161.

Before his election in November 1952, President Dwight D. Eisen-hower pledged to the American people that he would break the diplomatic and military stalemate in Korea and end the war. Despite his best efforts, little progress was made until the unexpected death of Joseph Stalin on 5 March 1953. Stalin had strongly supported a continuation of the war by the Chinese and North Korean Communists. He believed that having the United States entangled in an endless war on the Asian continent gave Russia an inherent geopolitical and military advantage in the Cold War, particularly in Europe where, he believed, the next world war would begin.

The absence of Stalin's influence permitted the Russians, Chinese, and North Koreans to reassess their positions concerning a political settlement in Korea. Within days, Georgi Malenkov, Stalin's successor, signaled a softening of the Soviet position and an interest in a negotiated settlement. This was followed by communications from the Chinese and North Korean leadership suggesting a resumption of peace negotiations and a transfer of sick and wounded prisoners of war (POWs).

The Military End Game

The peace talks resumed at Panmunjom, Korea during April 1953, but the fighting continued. Sixteen divisions of the Eighth United States Army in Korea (EUSAK) manned the Main Line of Resistance (MLR), roughly corresponding to the 38th Parallel. The First Marine Division defended a section of the MLR in west Korea, protecting the approach routes to Seoul, the Korean capital.

In late March 1953, the Chinese Communists conducted an intense, determined attack against three key Marine outposts designated Carson, Reno, and Vegas. The Nevada Cities battle lasted 5 days and resulted in 1,015 Marine casualties.(*1*) Two Navy hospital corpsmen were awarded the Medal of Honor for their heroic performance during the battle.

HN Francis C. Hammond lost his life assisting the evacuation of wounded Marines after his unit had withdrawn.(*2*) HM3 William R. Charette was wounded when he threw himself on an enemy grenade to protect an injured Marine.(*3,4*)

Throughout the April-June 1953 period, each side conducted repeated small unit actions to gain tactical advantages, to capture hostages, or to maintain a fighting edge. Heavy fighting again broke out in July 1953 as the Chinese and North Korean Communists attempted to gain additional ground for political advantage in anticipation of an imminent armistice.(*5*)

Peace at Last

Operation Little Switch, the first exchange of POWs, began on 20 April 1953. Among the 149 Americans released were 3 Navy corpsmen: HM3 Billy R. Penn, HN Thomas A. Scheddel, and HN Thomas H. Waddill.(*6*)

Debriefings of the newly released POWs revealed widespread mistreatment of prisoners that surpassed the worst expectations of the United Nations Command. HM3 Billy Penn's remembrances of his abusive treatment as a POW were typical of the many stories told. He arrived in Korea on 13 February 1953 and was immediately assigned to a Marine unit south of Seoul. On a voluntary mission to provide medical support to the Vegas outpost, he was involved in desperate hand-to-hand combat with Chinese Communists troops. While caring for a wounded Marine and fighting off attackers, he, himself, was wounded in the left ankle, left knee, and right shoulder, and taken prisoner. He described his internment:

I was in isolation for a long time. My isolation "domain" was a hole in the ground five and a half feet long, three feet wide, and four feet deep with several 2 x 4 boards about one inch apart covering the opening. This turned out to be the camp's latrine.... This was where they retrieved me for the firing squads.

Food was a very small handful of rice daily. Then, I had 15 to 16 straight days of fake firing squads. They would go through "ready, aim, fire," then click. At that time, I was hoping they would kill me. That takes a lot out of you. Once or twice they'd send a live round close to my head into the rock wall behind me to get my attention.

Name, rank, and serial number didn't seem to impress them. They had never heard of the Geneva Convention. For me, the brainwashing really started then. After a few rifle butts to the head and body...I was accused of germ warfare....

We had a Chinese interrogator.... We named him "Blood on Hands" because he kept reminding us we had Chinese blood on our hands.... He informed us that we had killed 5,000 Chinese.... He kept trying to get me to sign the germ warfare papers, inform him of our battle strength and so forth....

One time after a firing squad, he told me that my mother, father, and brother were killed in a car wreck.... I asked him about my sister. He said she was also killed. By that time, I was pretty mad. I informed him that he was lying. I had no sister. He hit me and called in some guards. They held me down and pulled my fingernail from the right ring finger with pliers.(7)

The on and off peace talks, which began during July 1951, intensified after the agreement on Operation Little Switch. Both sides were ready to negotiate a diplomatic solution to the interminable war.(*8*) The involuntary repatriation of Communist POWs who wanted to stay in South Korea remained the most contentious issue, but the deadlock was broken with the bilateral acceptance of a Neutral Nations Repatriation Commission to process all requests for political asylum. In June 1953, a final agreement was reached on the release of prisoners. This was followed by an agreement on a demilitarized zone (DMZ) of 2,000 yards each side of the military demarcation line, roughly coinciding with the 38th Parallel, the boundary between North and South Korea when war broke out on 25 June 1950. Finally, on 27 July 1953, an armistice was signed at Panmunjom.(*9*) The controversial, seemingly endless, and to many, pointless war was over.



Photo courtesy of Billy Penn, MD.

HM3 Billy Penn, USN

Operation Big Switch

Operation Big Switch, the final transfer of POWs, began on 5 August 1953 and continued to 6 September 1953. The United Nations Command exchanged 75,799 Communist

POWs for 12,757 Allied Command POWs (3,597 Americans).(*10*) As in Operation Little Switch, the returned prisoners were taken to Freedom Village, medically evaluated, treated, and triaged.(*11*) Four hundred thirty-eight POWs were considered to have a serious medical condition and were flown to Navy hospital ships at Inchon harbor or to receiving hospitals in Japan.(*12*) Four percent of the returnees had evidence of tuberculosis, about 2 percent had malaria, and 16 percent malnutrition.(*13*) The most common medical problem experienced by the POWs was dysentery.(*14*)

Neuropsychiatry problems were present in approximately 3 percent of the returned POWs.(*15*) Some were labeled as psychotic; others were diagnosed with a variety of stress-induced disorders resulting from psychological abuse they endured in the prison camps. In retrospect, many of these individuals had post-traumatic stress disorder, a diagnosis unknown at the time, which contributed to higher rates of death from accidents, addictions, and other mental disorders after discharge from military service.(*16*)

Many prisoners of the Communists never returned. Almost 38 percent of American POWs did not survive their internment in Communist prison camps, a death rate more than three times the death rate for prisoners of the Axis powers in World War II.(*17*) Of the 221 captured Marines, 12.2 percent died in captivity.(*18*) Most of the deaths were ascribed to varying combinations of malnutrition, mistreatment, combat wounds, and infection.(*19*) Some deaths were designated as "give-up-itis," attributable to loss of hope of rescue or release. Twenty-one American POWs succumbed to Communist indoctrination and refused repatriation.(*20*)

All returnees received extensive intelligence interrogations. Based on eyewitness testimony, 192 American POWs were charged with serious offenses against their fellow prisoners or collaboration with the enemy.(*21*) Although only a small number of men were involved, the sensational revelations of Americans refusing to return home and charges of treason and misconduct stigmatized all returning POWs and led to congressional inquiries and a revision of the Code of Conduct.



HM3 Andre Evans recovering from wounds on board *Repose*.

Mission Accomplished

During the 3-year conflict, there were few patriotic rallies supporting American men and women fighting in Korea. After the war, there were even fewer parades and celebrations to greet the returning veterans. Most Americans were eager to forget the long conflict—a war most neither understood nor supported. The combat statistics did little to assuage the sentiments of the American people. Nearly 1.5 million American men and



Two Navy corpsmen treat a Marine wounded in a mine explosion.

women fought in Korea. Over 100,000 were wounded, and more than 33,000 killed in action.(*22*) The Marines reported 26,038 wounded and 4,262 killed,(*23*) suffering relatively heavier losses than any of the services.(*24*) One hundred seven corpsmen died assisting wounded Marines, experiencing a higher rate of casualties than the Marines they were supporting.(*25*)

Gallantry was conspicuous among members of the Navy Medical Department. Navy medical personnel received 1,115 major awards, including 5 of the 7 Medals of Honor awarded to Navy personnel.(*26*) The Medical Department recipients were: HN Richard Dewert, HN John E. Kilmer, HM3 Edward C. Benfold, HN Francis C. Hammond, and HN William R. Charette. But for the latter, they were all posthumous.

For most in the Medical Department, the only reward was the knowledge that they performed their duties professionally and faithfully, continuing the high standards and traditions of Navy medicine. Their honor is written into the record of their remarkable achievements. Beginning with the deployment of the Medical Section of the First Provisional Marine Brigade under the leadership of CAPT Eugene R. Hering Jr., MC, in August 1950, Navy medical personnel supported Marine combat operations from the anxiety ridden days of the Pusan Perimeter defense, through the glory days of the Inchon landings, the horrors of the Chosin Reservoir campaign, and the misery of combat during the last 2 years of the war. In the process, they developed the most efficient, effective system of combat casualty evacuation and care in the history of warfare.(*27*)

The Forgotten Victory

Historians continue to debate the significance and consequences of the Korean War, especially during this 50th anniversary period. The current diplomatic impasse between the United States and the Democratic People's Republic of North Korea over nuclear weapons has generated a heightened interest and added poignancy to these discussions. The Korean War produced neither victors nor vanquished. It ended where it started; Korea did not become a united, democratic country. North Korea remains a threat to the peace and stability of the Korean Peninsula and East Asia. From this limited perspective, the Korean War was an unfortunate mistake, a war of failed diplomacy and mistaken military calculations.

The events of the latter half of the 20th century, however, demand a broader interpretation. The Korean War was the first military confrontation of the Cold War, a perilous struggle between the Free and Communist worlds marked by hostile diplomacy, propaganda, and nuclear threats. In Korea, the United States demonstrated its unqualified willingness to oppose Communism by all means including war. The Korean War was the prototype of limited warfare, proving that wars against Communist aggression could be fought regionally without the use of nuclear weapons. The pursuit of this containment policy led to American involvement in Vietnam, but without the steadfast commitment to the policy, the collapse of the Soviet Union and the destruction of the Iron Curtain might not have occurred. Without the actions taken by President Truman during the last days of June 1950, the United States might not have won the Cold War.

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1. LCOL P Meid, USMCR, and MAJ JM Yingling, USMC, "Operations in West Korea," in *U.S. Marine Operations in*

Korea, 1950-1953, Vol. V. (Washington: Historical Division, Headquarters U.S. Marine Corps, 1972), p. 307.

2. Ibid., p. 287.

3. Ibid., p. 294.

4. Five Navy hospital corpsmen were awarded the Medal of Honor for heroism in the Korean War.

5. During July, the Marines experienced 1,611 casualties, their heaviest of any month during 1953. For details, see Meid and Yingling, p. 391.

6. These were the only Navy hospital corpsmen captured during the war.

7. Taken from the testimony of HM3 Billy Penn, captured at Vegas outpost and held as a POW until released in "Little Switch" in April 1953. In March 1995, at the request of former Commandant of the Marine Corps, GEN Robert H. Barrow, Penn chronicled his experiences as a prisoner of war. Testimony can be found in the Korean War files, Bureau of Medicine and Surgery Archives, Washington, DC.

8. Syngman Rhee, President of the Republic of Korea (South Korea), wanted to continue the war. He was intent on reunifying the two Koreas and tried to subvert the peace negotiations but finally gave in to U.S. diplomatic pressure.

9. Only an armistice was signed. There has never been a peace treaty among the nations that fought the war. American soldiers still patrol the DMZ.

10. Meid and Yingling, p. 407.

11. Freedom Village was the processing center for the American POWs exchanged at Panmunjom. Engineers of the First Marine Division constructed it, and the 11th Evacuation Hospital, a Mobile Army surgical Hospital (MASH), staffed it.

12. Cowdrey, *The Medics' War*. (Washington: Center of Military History, United States Army, 1987), p. 353.

13. Ibid., p. 354.

14. Ibid., p. 353.

15. Ibid., p. 354.

16. Post-traumatic stress disorder was first recognized as a psychiatric disorder in 1980 when it was included in the *Diagnostic and Statistical Manual of Mental Disorders (DSMIII)*, the official manual of the American Psychiatric Association.

17. Meid and Yingling, p. 411.

18. Ibid., p. 410.

19. According to Philip D. Chinnery, historian for the National Ex-Prisoners of War Association, 1,615 atrocities and war crimes were reported involving 10,233 American victims. For a detailed exposition of this issue, see his book, *Korean Atrocity!: Forgotten War Crimes, 1950-1953*. Annapolis: Naval Institute Press, 2000.

20. Meid and Yingling, p. 442.

21. No Marines were indicted for serious crimes committed while imprisoned. One enlisted Marine was disciplined for writing a pro-Communist magazine article. One Marine officer, COL Frank H. Schwable, appeared before a court of inquiry, but was exonerated. For a comprehensive study of Marine Corps prisoners, see J.A. MacDonald, Jr., *The Problems of U.S. Marine Corps Prisoners of War in Korea*. Washington, DC: History and Museums Division, U.S. Marine Corps, 1988.

22. The exact number of Americans who died during the Korean War remains unsettled. The estimates range from 32,000 to 36,000. Meid and Yingling (p. 532) use GEN Matthew Ridgway's total of 33,629 found in his book, *Korean War*.

23. Meid and Yingling, p. 575.

24. Department of the Navy, Bureau of Medicine and Surgery. *The History of the Medical Department of the United States Navy, 1945-1955*. NAVMED P-5057, p. 183.

25. Ibid., 185.

26. Ibid., 185.

27. The techniques of combat casualty evacuation and care changed radically during the Korean War. Some of the innovations were the use of helicopter evacuation, improved techniques of wound care, deployment of frontline surgical hospitals, and refinements in vascular and neurosurgery. Mention should also be made of the importance of the armored vest and thermal boots that prevented many casualties. For a discussion of the impact of these developments, see Department of the Navy, Bureau of Medicine and Surgery. *The History of the Medical Department of the United States Navy, 1945-1955*. NAVMED P-5057, pp. 182-184.

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Naples Delivers The Birth of a Naval Hospital

JO1 Joseph Kane, USN

The first moments of life are something that some doctors witness on a regular basis. But the birth of an entire hospital is an unusual sight, even to those accustomed to delivering newborns. In Naples, the upcoming opening of the new naval hospital at the Naval Support Activity Gricignano support site marks the beginning of a new era for military healthcare in the area.

According to CAPT Kathleen O'Farrell, commanding officer of U.S. Naval Hospital Naples, the current facility in Agnano has served the Naples military community since 1968. Over the last few years, damage from earthquakes and increasing demands for modernization have caused Naples' military community planners to conclude that a new hospital was necessary.

"After a series of earthquakes in the Pozzuoli-Agnano region during the 1980s, the hospital was severely damaged and a decision was made that the hospital would have to be replaced to keep pace with the latest seismic requirements," O'Farrell said. "Also, the current hospital is antiquated, difficult and costly to clean and maintain, and located far from the expanding residential center for military personnel in the Naples area.



Photo courtesy of author

U.S. Naval Hospital Naples.

Therefore plans were set in motion that resulted in the awarding of a construction contract in July of 1998 to build a new facility in the Gricignano area at the support site."

The conception, gestation, and labor pains of bringing a new hospital to life are something that HMCS Chris Atamian is very familiar with. Atamian is the health facilities planning and projects officer for the construction of Naples' latest addition. Atamian said one of the biggest challenges during the process was meeting both European and U.S. building codes.

"Because there are some differences, we decided that we would evaluate each code and then apply the code that was more stringent," Atamian said.

O'Farrell said that during the design phase, a new seismic code from the United States was instituted, and the designer and builder had to include the code into the design, add-

ing to the cost and design time. Also, the Italian government required a thorough archeological excavation on the site prior to construction.

"During the archeological digs prior to construction, many Roman artifacts were discovered and turned over to local authorities," O'Farrell said. "A 2,000-year-old Roman well was discovered and has been preserved in place and incorporated into the design so that visitors can observe the ancient well when visiting the hospital."

Other challenges included various legal issues and planning and scheduling conflicts, but Atamian said throughout the process working in close coordination with everyone involved helped to ultimately reach the goal.

"It was a huge effort," Atamian said. "There are several of us over on the OICC [Office in Charge of Construction] side, probably eight engineers who worked the project, four primary and then four additional Quality Assurance inspectors. On the Italian side, there were five lead groups including mechanical, electrical, and architectural as well as biomedical engineers. So between all of us, we had to coordinate every issue and we had to integrate several U.S. pieces of medical equipment into an Italian facility. We met, even in the early stages, once a week and then toward the end nearly daily."

Atamian pointed out that normally in a construction project this size it would take 4-6 months after accepting the building to install all the furnishings and equipment. But in this case, they worked out a plan enabling early work to start even as construction was ongoing, he said.

"What we did was to negotiate early access so that we could move in much of the furniture and medical equipment on top of their construction so that the building tie-ins and infrastructure were coordinated during construction, "Atamian said, "so that when we actually signed for the building and picked up the keys, there would be fewer things to finish up."

The developer turned over the building to the Navy 23 April, and the hospital staff started seeing patients 16 June, with a ribbon cutting 20 June.

O'Farrell said the new hospital will provide state-of-the-art equipment for local beneficiaries and, due to its location, will be more readily available to a large number of beneficiaries living in the support site area. Some of the new equipment and facilities include:

—Magnetic Resonance Imaging—USNH Naples currently uses local Italian MRI resources (average of 25 MRI studies/month). These patients will now receive these studies at USNH Naples.

—Filmless digital X-ray processing and the ability to send film images to other facilities with similar technologies.

—More exam rooms, dental operatories, and operating rooms (from two to four).

—Central air conditioning and a medical gas system throughout the building.

—The latest computer technology, including video teleconferencing (VTC), which will be available in several meeting, conference, and class rooms so that staff members will have improved access to VTC conducted meetings and educational offerings (many conducted from the United States or Germany).

—A centralized patient-monitoring system throughout the building with wireless patient physiological monitoring, so that the Emergency Room staff can monitor a patient in radiology getting a chest x-ray or during transfer from one department to another.

—Consolidation of all hospital services presently spread out in four separate buildings in the Agnano area into one building.

—LDRP rooms. These rooms replace the traditional, labor, delivery, and in-patient rooms. In these rooms, a pregnant woman will go through labor, deliver her baby, recover from the delivery, and spend her post-delivery period. Providing the woman does not have a C-section, she will remain in this one comfortable, homelike room through her whole birthing experience.

O'Farrell said that the number of patients treated will not significantly increase, but the range of capabilities will certainly improve. "For the past 2 years, USNH has admitted and treated [as in-patients] a little over 700 patients per year," O'Farrell said. "This is not expected to change with movement into the new facility. Outpatients treated at the hospital average about 55,000 per year. This number of outpatients may increase slightly with movement into the new facility, due to proximal location to housing and improved customer ease of access since the current Agnano location is not close to base housing.

"The USNH staff is committed to the delivery of high-quality, safe care for our beneficiaries. That will be the primary focus during this transition period—ensuring every patient receives the timely, appropriate care they need," O'Farrell said. ❑

JO1 Kane is Public Affairs Officer, U.S. Naval Hospitals Naples.

The Unsung Rodeo Corpsman



Photo courtesy of MH2 Maurer

Maurer rides the bull.

Some years ago, television journalist Charles Kuralt traveled around the U.S. in an RV searching for America. What he found were human interest stories that spoke more profoundly then any news of the day. Kuralt might be gone but slices of Americana are still very much in evidence around us. Case in point: Navy medicine's own HM2 Chris Maurer. Maurer works at the Bureau of Medicine and Surgery as a physical exams qualifier during the day. After hours he is a champion cowboy on the rodeo circuit.

Maurer's initiation into the rodeo world started on a bet. "I was with some friends that rodeo at a practice pen, watching them ride bulls. One of them said that nobody riding horses could get on a bull and ride it the first time out. I took them up on their bet and rode that bull for 8 straight seconds without getting bucked off." And thus his penchant for rodeo began.

"I began riding 'rough stock.' Rough stock is everything and anything that wants to throw you off its back. These include bulls, saddle-broncs, and bareback bronc events."

The goal is stay on the animal for 8 seconds. And for those of you who think staying on a raging bull for 8 seconds looks as easy as that mechanical bull scene in "Urban Cowboy," think again. "Eight seconds doesn't seem all that long, but believe me it is the longest segment of your life when something is snatching you around like a dog with a bone," Maurer insists.

Needless to say, rodeo riders suffer quite a few injuries, but they seldom allow such injuries to slow them down. "Just last year, a friend of mine in a rodeo in Glens Falls, NY, came off his horse and landed on the ground in such a way that he tore his anterior, posterior, and medial cruciate ligaments, and had a meniscus tear in his right knee." He was back on the rodeo circuit in 2 months.

Maurer has not been without his share of injuries either. In 1999 a 1,900 pound bull "stepped through" his chest, breaking five ribs and collapsing a lung. On another occasion, he broke his collar bone in four pieces. Concussions are another hazard of the rodeo circuit, but as Maurer laughingly quips, "I've made head-to-head contact with bulls, but I've never suffered a concussion, at least as far as I can remember."

So, what's the charm in getting bruised, beaten, and snatched around like a wet noodle for 8 seconds? Maurer admits to being labeled as an adrenaline junkie but this doesn't stop him from traveling to Professional Rodeo Cowboy Association (PRCA) and Professional Armed Forces Rodeo Association (PAFRA) events around the country. The rodeo season is year round. According to Maurer, military rodeos are getting larger every year. "PAFRA is full of cowboys from all branches of the armed forces. The commands with the best rodeo riders get the bragging rights." Because rodeo competitions are often held in Texas, the Navy does not have as large a representation that the Army and Air Force can present.

In 1997 Maurer went to the Military World Finals as the reigning Atlantic Circuit All-Around Cowboy.

This circuit encompassed the area from the eastern seaboard to the Mississippi River. In 2002 he qualified for the bareback finals. "I actually had it pretty easy. I drew fairly well as far as stock goes, but the one thing I did that most people were unable to do was to stay on all the horses I climbed onto."

As for future rodeo aspirations Maurer admits, "I'm not going to lie, I want the bareback world title and I think I can get it. In fact, I know I can. BUMED has been very supportive in backing me, making sure I get to the events. This year it looks as though we are going to have more competitions in the Northeast. I'll have more chances to attend rodeos in this area. I would be rodeoing anyway, so I'll be able hit more of them."

When talking to Maurer, one notices that he neither complains about his injuries or the resulting aches and pains caused by them. He says his philosophy toward rodeo riding is the same as his philosophy on being a corpsman. "When you're out in the field with the Marines and it's cold and nasty and you don't want to keep going, what do you do? Quit? No, you do what has to be done and keep going. Earlier this year, while competing in the rodeo, I had a string of wrecks. I had someone help me into the chute because my leg was so beat up from getting stepped on. I got up on the horse and made the best ride of my life. When I got off she managed to get one last kick in on me, and pushed me down into the ground. As the pickup man was trying to help me up, I slid face down and slashed my nose on his spur. I ended up with six stitches in my nose. But if anyone were to ask me if I would do it again, I would in a heartbeat." This is the true testament of a cowboy and a corpsman. ❑

—Story by André B. Sobocinski, Assistant Historian, and staff writer for *Navy Medicine*, Bureau of Medicine and Surgery (M09H), Washington, DC.

Rodeo Glossary of Terms

Average: scores on all go rounds (see below) plus the score on the short go (see below). Whoever has the highest average wins.

Bareback bronc: a horse whose rider isn't using a saddle but is hanging on courtesy of a strap around the horse's rib cage.

Barrel man: the rodeo clown, an important factor in the bull riding event. He hides in a barrel until he is needed to distract a dangerous bull from injuring a thrown rider; also leads a dismounted bull away from the cowboy and out of the arena; a good clown can also coax a better performance out of a bucking bull before he is dismounted.

Circuit finals: regional finals before the championship. Texas is the only state that has its own circuit.

Clover leaf: the route contestants in the barrel race follow.

Dogie: a motherless, or wild, calf.

Free hand: in rodeo riding events one hand must stay free at all times.

Go round: a contestant's turn at a rodeo event.

Good bucker: a bucking horse or bull admired by the contestants.

Hooker: a bull who, when he bucks, throws the rider forward so that he can hook the rider with his horns.

Houlihan: the head-over-heels tumble a steer takes in the steer wrestling event.

Low time: the winner in a timed rodeo event.

Luck of the draw: the animal most likely to give a contestant a good (high) score.

Marking out: the position of the rider's feet over the shoulders of a bucking horse as it makes its first jump out of the chute.

PRCA: Professional Rodeo Cowboy's Association.

NFR: National Finals Rodeo.

Perfect score: one hundred points (fifty for the rider; fifty for the horse or bull). A rider can execute a perfect ride by not getting thrown, by having good style, and by riding a wild animal well. A horse or bull is perfect if they give the rider a harrowing ride and then throw him at the last minute. There has never been a 100-point ride in the saddle-bronc event and only recently was a score of 100 awarded in bull riding, much to the consternation of rodeo performers everywhere. As saddle bronc rider Craig Latham notes, "If the bull or a horse does a perfect job, then you're on the ground." And that's not a perfect score for the rider.

Pickup man: a rider in the arena who helps a contestant off a bucking horse.

Saddle bronc: a horse ridden by a rider using a rough out saddle and a cloth rein.

Short go: a turn at an event in the championship round.

Spinner: a bull that spins or turns as if chasing its tail. Scores high, especially if it spins both left and right.

Stampede: an out-of-control herd of cattle.

Team roper: a member of a two-person roping team. One ropes the steer by the horns and the other ropes the steer by the rear feet. ❑

"Tiffany" Medal of Honor Comes to Navy Museum

Michael Birnie



U.S. Navy Photos

"Tiffany" Medal of Honor

Thanks to the FBI, the Navy Museum has recently acquired the Medal of Honor awarded posthumously to Navy dentist LTJG Weedon E. Osborne for valor during World War I. The medal is a rare example of the "Tiffany Cross" type.

Dr. Osborne's MOH came into the hands of the FBI in 2002 after an attempt to sell it in South Carolina. Under an Act of Congress, it is illegal to sell any Medals of Honor within the territorial limits of the United States.

Tim Frank, historian for the Medal of Honor Society, first made the museum aware of the medal and, recently, the FBI agreed to release it to be eventually displayed in the museum's World War I exhibit.

Osborne received the medal for heroism in France, 6 June 1918, during the Battle of Belleau Wood. Osborne, attached to the 6th Marine Regiment, rescued CAPT Donald Duncan, who had been severely wounded by machine gun fire. However, before reaching safety, both men were killed by a shell that landed nearby. For his valor, in addition to the Medal of Honor, Osborne also received the Distinguished Service Cross.

Prior to World War II, the Navy Medal of Honor could be awarded for both combat and non-combat actions. Osborne's Medal of Honor is significant because it is a rare "Tiffany Cross" edition first introduced by the Navy Department in 1919 to be the combat version of the medal. Awardees for non-combat actions still received the original (and current) medal design.

The "Tiffany Cross" comes from the medal being originally designed by the famous jewelers Tiffany & Company of New York. The cross was not a popular award and is the rarest of all Medals of Honor in existence. In 1942, the Navy returned to the original medal design for combat awards and abolished non-combat awards of the Medal of Honor.

The medal bears the blue silk ribbon of the Maltese cross below the bar bearing the word "Valour." The medal itself features the American eagle in the center surrounded by a six-sided border, over the top of which is printed "United States Navy" and below "1917-1918." The four arms of the cross bear Navy anchors. On reverse, the medal has the words "Awarded To LTJG Weedon E. Osborne, United States Navy."

"This is a significant addition to the museum collection, as LTJG Osborne was only one of four naval surgeons to receive this award. He was also one of only two Navy dentists to receive the Medal of Honor," said Navy Museum Curator Dr. Edward Furgol. ❑

Michael Birnie is with the Navy Museum Public Affairs Office, Washington, DC.



Navy Museum



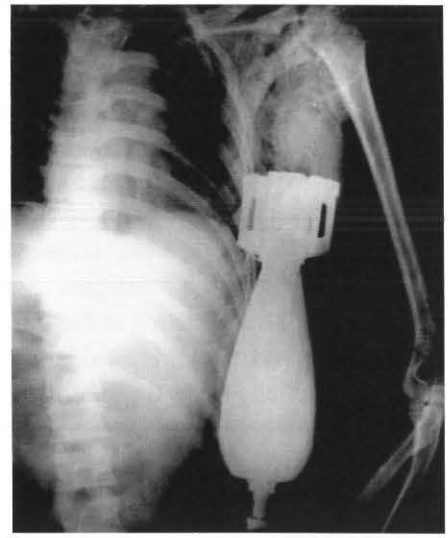
CAPT Harry H. Dinsmore, MC, USN, (Ret.) died 7 April in Pittsburgh. He was 79. Dr. Dinsmore was born on 7 March 1924. After completing pre-medical training at West Virginia University, he graduated from Georgetown Medical School in Washington, DC, in 1948. He did his internship at the National Naval Medical Center Bethesda, and surgical training at Naval Hospital Philadelphia.

From 1966 to 1967, Dr. Dinsmore was Chief of Surgery at Naval Support Activity hospital, Danang, Republic of Vietnam. It was during that tour that he performed an unusual and highly perilous surgery that has become legendary. The patient, a South Vietnamese soldier, had been riding in an armored personnel carrier near Danang in the late afternoon of 1 October 1966 when he spotted a Viet Cong mortar squad. It was already too late. A Soviet bloc-made 60mm round struck the open hatch, deflected off his steel helmet, penetrated soft tissue between collarbone and shoulder, then plunged beneath his skin before coming to rest below the left armpit. Within minutes, his comrades rushed him, still conscious but terrified, to the nearby U.S. Naval Support Activity hospital. An x-ray revealed that the live round with its fuse partially depressed, could explode at any moment. Although there were other surgeons on the staff, Dr. Dinsmore felt that he could not ask or order them to do the surgery. He would do it himself. In an 1989 interview, he described the most terrifying 30 minutes of his life:

I chose not to do a skin prep; [Explosive Ordnance Demolition expert, John] Lyons urged that there be no movement of the round within the tissue, no twisting or lateral motion. He felt the round should not be moved at all until it was lifted straight from the chest wall. To accomplish that end, I planned to make an elliptical incision completely around and away from the mortar shell. I proceeded with the surgery.

When the round had been completely encircled, I lifted it with the overlying soft tissues directly away from the chest wall, thinking every second that my world was going to end, as the shell was just a foot from my face.

*Just then, a major problem became evident. As the shell came away from the chest wall, I felt something restraining it. The patient's blood-soaked shirt, which was also firmly trapped within the entrance wound, was badly entangled in the mortar round's tail fins. With a Mayo scissors, the heaviest we had, I spent an additional, harrowing 10 minutes cutting through multiple folds of heavy, wet cloth to get it free. I handed the shell, with the surrounding tissues, to Lyons and then hurried over to open the door for him. He took the round to a nearby sand dune, where he defused it and emptied the TNT. He later returned it to me as a keepsake.**



Following his return from Vietnam, CAPT Dinsmore served at NNMC Bethesda until his retirement in 1967. He then practiced medicine in Punxsutawney, PA, for the next 24 years.

CAPT Dinsmore was board certified in general surgery and was a Fellow of the American College of Surgeons. He held the Navy Cross, the National Defense Medal, Navy Unit Commendation, American Campaign Medal, Vietnam Service Medal, World War II Victory Medal, Navy Occupation Medal, Republic of Vietnam Medal, and the Vietnamese Cross of Gallantry with the Silver Star. ❑

*See *Navy Medicine*, Nov-Dec 1989.

The Navy medical community mourns the loss of HM3 Michael Vann Johnson, Jr., of Little Rock, AR. Johnson, a hospital corpsman with the 3rd Battalion of the 5th Marine Expeditionary Force in Iraq, was killed in action on 25 March 2003. He was 25. ❑

ENS Jerry "Buck" O'Neal Pope II died following an automobile accident in October 2002. He was the first and only Navy Physician Assistant (PA) to die during Operation Enduring Freedom. He was 34.

ENS Pope was born in Tallahassee, FL, and graduated from Leon High School in 1985. His desire for competition and athletics along with his fervent patriotism led to enlistment in the Navy as a SEAL. Upon graduation from Basic Underwater Demolition School, Petty Officer Pope was assigned to SEAL Team FOUR at Little Creek, VA.

Pope's reputable work as an instructor at the Joint Special Operations Medical Training Center, Fort Bragg, NC, coupled with a prestigious academic record at Campbell University and the University of Nebraska paved the way for his selection in the Interservice Physician Assistant Program (IPAP). Immediately following assignment at the Branch Medical Clinic Quantico, VA, he volunteered for an arduous and demanding TAD that took him overseas. It was during this assignment in San'a, Yemen that he died. ❑

Book Review

War and Public Health edited by Barry S. Levy and Victor W. Sidel. Oxford University Press. New York. 412 pages, 1997.

Many members of Navy medicine who have been operational or are serving on platforms augmenting operational forces are usually a moment away from conducting a humanitarian operation. These missions are usually the most complex for our forces and require active participation of Navy and Marine Corps medical assets in the planning and advising of line commanders. Thus far, the Navy has participated in many operations that provide relief for man-made or naturally caused disasters. These include humanitarian missions in Central America, Africa, the Balkans, and Asia.

Barry Levy, President of the American Public Health Association, and Dr. Victor Sidel, a professor of social medicine at Montefiore Medical Center, bring together a collection of experts in this book. The authors range in experience from non-governmental organizations (NGOs), United Nations relief organizations, and human rights advocacy groups, and write about war and its effect on public health.

The book has seven parts, each containing between two and six chapters. Part three discusses the effects of weapons on public health and specific chapters are dedicated to each of the categories of weapons of mass destruction. One chapter on land mines analyzes not only the physical damage inflicted by mines but also the psychological trauma and social stigma suffered by amputees in underdeveloped nations. The chapter also highlights several inexpensive and innovative prosthetics that include the Jaipur Foot, developed in India and costing under $30, and the Seattle Shapemaker, a springy, lifelike foot that is also inexpensive to manufacture.

Another chapter describes the psychological effects of war on children from a developmental, social, and physical perspective. It cites examples from the Lebanese civil war, Palestinian refugee camps, and Cambodia, and illustrates how children caught in war are gradually desensitized to killing and torture.

Part five examines Vietnam, Central America, and the Persian Gulf and how war in these places affected public health.

The final section deals with the ethics of NGOs and the challenges of providing medical care to combatants and non-combatants alike. Here the authors point out the limitations of NGOs and their occasional reluctance to deal directly with military forces providing relief.

For those involved in operational medicine, *War and Public Health* provides some very useful insights. The appendix includes a list of organizations involved in humanitarian relief with their website addresses. The featured websites provide a wealth of information on areas of operation and can supplement military sources. ❑

—LCDR Aboul-Enein is a Medical Intelligence Officer currently assigned as Middle East Country Director at the Office of the Secretary of Defense.

Navy Medicine 1944



BUMED Archives

Navy nurse Ensigns Nina Wackerle (left) and Dorothy Jane Watson, learn the bagpipes at the London Red Cross Club.

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